HIPAA RELEASE AUTHORIZATION FORM

Patient's First Name _____ Last Name _____

Address _____ Patient's Date of Birth _____

City, State Zip Code _____ Patient's Telephone Number _____

I hereby authorize Clinic to release protected healthcare information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

2. The following person (or class of persons) may receive disclosure of protected healthcare information about me:

   Name: _____ Name: _____

   Relationship: _____ Relationship: _____

   Phone: _____ Fax: _____ Phone: _____ Fax: _____

   Email: _____ Email: _____

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

5. I may revoke this authorization by notifying Clinic in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. This authorization does not have an expiration date unless specified: _____

   Initial Here

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Patient's Signature	Date	Last 4 Number of Social Security Number
Signature of Parent/Guardian or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual